Justice Center Abuse Prevention Committee

MEETING SCHEDULE/AGENDA - December 2021

1. December 7, 2021 1pm-2:30 pm
    - Welcome
    - PQI Updates (15 min)
    - Mortality Review/OGC- Mortality trends (60 minutes)
    - Best Practices updates- Inadequate Medical Care (15 min)

2. December 9, 2021 1pm-2:30 pm
    - JC SART- Trends and outcomes (30 min)
    - Updates on Injuries of Unknown Origin (30 min)
    - Next steps (15 min)

Summary

Justice Center Prevention Committee Update: The Justice Center's internal abuse prevention committee charged with identifying preventative actions that can address conditions that cause or contribute to incidents of abuse and neglect held meetings in December 2021. During these meetings, the committee received updates and trends from the Justice Center Sexual Abuse Response Team, trends from abuse and neglect cases with a death involved, improvements in the investigations of injuries of unknown origins and an update on 2021 abuse prevention projects.

Each year, the Justice Center sexual abuse response team investigates approximately 600 cases involving allegations of sexual abuse. In 2021, 21 percent of the cases reviewed by this team were substantiated. Most of the substantiated cases were substantiated for neglect, primarily for failure to maintain professional boundaries.

In 2021, the Justice Center closed 66 abuse and neglect cases with a death involved and 21 of those cases had at least one allegation of neglect substantiated. There was only one case in which the neglect directly caused the death of the person receiving services. In ten cases, neglect was not a direct cause of death but contributed in some way and the in the remainder the neglect was either unrelated or undetermined if there was a causal connection between the neglect and the death. The most frequent types of neglect were inadequate medical care, choking on food and failure to do checks as required.

The Justice Center has developed many resources for investigators who are investigating injuries of unknown origin. The Justice Center defines an injury of unknown origin as an injury that either wasn't witnessed and/or can't be reasonably explained by the victim or others and raises the suspicion for abuse and neglect. These

resources include recorded trainings, case worksheets and guidance on a variety of topics. There is also a peer consult and review committee for Justice Center led investigations into injuries of unknown origins.

In 2021, the Justice Center developed an internal abuse prevention resource guide to help investigators refer provider agencies to our prevention materials when appropriate. A link to the Justice Center's abuse prevention resources web page is now included in all the Justice Center's letters of determination concerning abuse and neglect allegations as well as CAP audits. The Justice Center also developed web based interactive training for maintaining professional boundaries. Two new prevention tool kits were developed: Best Practices for Body Checks and CAP Audit Guidance.

The Justice Center regularly evaluates case data for trends that can ultimately guide needed safety improvements. Recently, the Justice Center requested that OPWDD issue an alert and guidance to the field regarding the importance of following manufacturer instructions on Hoyer lifts after noticing a series of injures related to their use. At OPWDD's request, the Justice Center sent two years of data on incidents involving these specific lifts in OPWDD settings. OPWDD subsequently issued a Health and Safety Alert to the field titled "Important Information About the Use of Mechanical Lifts". The alert provides recommendations on implementing policies and procedures in keeping with NYS Safe Patient Handling Law and the FDA that include safe mechanical lift operation, equipment maintenance, staff training, and periodic review and revision of the policies and procedures.

In 2022, the abuse prevention committee will develop a best practice for medical care toolkit, complete a systemic review of choking incidents and develop best practices for supervision.